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ABSTRACT

This paper is intended for teachers, faculty instructors, and clinical supervisors whose trainees are evaluating and treating refugee patients. It addresses special issues in the diagnostic and therapeutic interviewing of refugee patients who have experienced various types of physical violence and victimization. After a brief introduction, a background section reviews the variety of contexts in which refugees may have been subjected to physical violence, including the "official" violence of torture and prison camps, and the unofficial, random violence of war zones or resettlement camps. The importance of the source of the violence is emphasized; it is easier to dissociate oneself from the violence of a despised other group than from violence perpetrated by one's own nationality, race, culture, or neighbors. It is noted that refugees may even have been forced to perpetrate violence on others, in order to survive, or they may feel responsible for the deaths or losses of others. Case histories are cited to illustrate these points, and the diagnostic purpose of interviews is highlighted in relation to such personal experiences. The remaining sections discuss the process of the interview and preparation for working with refugees, including the basic knowledge and skills required. (TE)

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Violence and Victimization in the Refugee Patient
I. Special Issues in Diagnostic and Therapeutic Interviewing

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INTRODUCTION

This paper has been primarily prepared for teachers, faculty instructors, and clinical supervisors whose residents, interns and fellows are evaluating and treating refugee patients. Many such patients are seen in medical centers that are involved in the teaching and training of clinicians. Educators and clinical supervisors should of course have experience themselves in the care of refugee patients.

Trainees often begin social and psychiatric histories at the time when the refugee patient arrives in the U.S.. Just as with any patient, the life-long history of refugee patients must be obtained. Since a large number of refugee have been subject to physical mistreatment and victimization, the refugee patient must be invited to discuss past experiences. As in any sensitive history taking, this must be done in the context of a continuing clinician-patient relationship, when rapport has been established, and when the patient is able to manage the stresses of such an interview.

Ethical considerations, and plans for psychiatric care (if necessary following the interview) must be addressed in the case of epidemiological studies outside of a treatment context. As in all such interviewing, the distinction between diagnostic and therapeutic interviewing is not a distinct one; both ends are often served concomitantly. It must be borne in mind that, as in any type of similar interviewing, the potential benefits must be weighed against the potential liabilities. This requires skill, knowledge and especially experience in dealing with refugee patients. This paper cannot serve as a substitute for adequate clinical supervision by an experienced clinician. Along with the patient, the trainee often requires support and encouragement in

undertaking this demanding and sometimes stressful work. Access to hospitalization should be available in case of exacerbation in the patients condition.

BACKGROUND

Refugees can become victims of physical violence in many ways. In some instances violence has caused their exodus out of the country-of-origin. Examples include survivors of Nazi, Laotian and Vietnamese prison and labor camps, the Jewish and Cambodian "Holocausts", or Chilean torture prisons. War or civil unrest may expose civilians to almost random violence, as has and is occurring in Central America, the Middle East, and parts of Africa. Victimization may occur during flight from the country- of-origin. This has happened to Vietnamese subject to pirate attacks in the Gulf of Siam, and to Hmong robbed and beaten by Thai gangsters. Physical assaults also occur in first-refuge countries and resettlement countries, especially when resented refugees are placed in poor rural or "ghetto" areas with little or no orientation or acquisition of "survival skills". Examples include assaults, rapes and robberies of refugees across Southeast Asia and in the United States.

Victimization may occur in several ways. An individual may be threatened by arrest or mock execution without physical violence. Victims may observe violence being perpetrated against others: friends or family members may be beaten, tortured, raped or executed in their presence. Individuals may be subject to random violence during bombardment or battle.

Purposeful violence may be focused on particular, selected individuals.

Source of the violence may be important. It may originate with an identified enemy, some from a different country, race, religion, ethnicity, or language. In the short run, this may make it easier to dissociate oneself from the violence, projecting it onto a despised other group. (Eventually, of course, the individual must deal with the fundamental fact of violence by one person or group against another person or group). Violence may be perpetrated by people of the same nationality, race, or culture. This makes it more difficult to dissociate oneself from the violence, and can precipitate self-hate or distrust of one's own people. Even neighbors may undertake violent assaults, as in this case:

> A 38 year old Hmong man was returning home on pay day to his public housing, situated in Southern California. Several neighbors surrounded him and demanded his salary money. When he refused two men grabbed him while a third prepared to search him. Using personal defense measures learned previously in the Laotian army, he freed himself, jumped on a nearby truck, and then to the roof of the project. One of the remaining neighbors then obtained a shotgun, discharging two shells at the refugee. Severe wounds in the abdomen and flank necessitated removal of his left kidney. Subsequently he developed minor but chronic symptoms of anxiety and depression, fear of leaving his home after dark, and -- although relocated to another ghetto -- fear of his environment. Although he had

participated in several battles with Vietnamese in Asia, he had not developed post- traumatic stress disorder symptoms relevant to his former military career.

Refugees may have been forced to perpetrate violence on others. For example, older children, pre-teenagers and early teenagers in Cambodia were sometimes required to perform killings in order to obtain food or to continue living themselves. Sometimes refugees feel responsible for deaths or losses, even though they did not perform violent acts themselves. This is especially apt to occur with group leaders, clan elders, or parents when someone for whom they feel responsible is lost, as in this case:

> A 41 year old Laotian refugee had led an escape from a concentration-labor camp in a remote area of Laos. Due to his familiarity with the country, his experience or similar wartime flights earlier, and his leadership capacities, he was able to maintain his entire group of eight persons in good health and free from recapture over several weeks. When finally swimming across the Mekong River to Thailand, the group came under small arms fire from the Laotian border. One of the group took a bullet in the head, dying immediately. The leader, at risk to himself, swam several hundred yards with the body to the Thai shore. Years later, following vandalism of his home by an adolescent neighbor, he began to experience nightmares of this event in the river, accompanied by a major depression.

RATIONALE FOR THE INQUIRY

Those unfamiliar with treating refugees sometimes question the need for obtaining information on violent events in the patient's background. The author has heard such expressions even from doctoral level clinicians. Their objectives generally fall into the following categories:

-- all refugees have been through violence, so it can merely be assumed;

-- expression of horrorific stories are disturbing to refugees;

-- the past cannot be changed, so that there is no reason to speak about these things;

-- philosophically, it is better to let these inhuman acts disappear from our individual and collective memories.

These objectives will be responded to in sequence.

All refugees have not been exposed to personal violence, or threat of it. Some leave their country-of-origin early, when the first "danger signals" appear, or even earlier when they anticipate eventual outcomes. Others are in school, at work, or visiting abroad and then simply apply for refugee status. No threat may exist for some people
who merely wish to join refugee relatives, avoid the draft, advance their education, or to seek better economic opportunity.

Even threatening or violent events may be viewed benignly by the individuals, although the elements of major threat or violence are present. In such cases the individual found redeeming aspects to the events or was able to rationalize or justify the events. The following three cases exemplify this:

-- A 21 year old single Hmong woman was seen in crisis with an out-of-wedlock pregnancy. At age 12 she had spent several weeks walking out of the mountains of northern Laos with her family and fellow villagers. She recalled the event quite fondly as a unique time when her polygamous family suspended their constant animosities, helped each other out, and showed their true concern and affection for each other. Hunger, fatigue, threat of landmines, and contact with a Vietnamese army patrol were all minimized.

-- A 32 year old Hmong widow presented with agoraphobia and panic attacks after she had been assaulted and robbed in a supermarket parking lot. Eight years earlier, her husband and her husband's minor wife had been blown apart in her view by a mortar blast while they were escaping across the Mekong River. Although she had grieved him at the time, she soon felt happy to be rid of him since he had taken the minor wife against the major wife's wishes, he used sparse family resources to shower favors on the minor wife, and -- during the flight across the river -- the husband had left the major wife to attend to their three small children alone while he attended to the minor wife.

-- A 58 year old Vietnamese veteran presented with a psychiatric depression and PTSD symptoms related to a 5 month period as a prisoner-of-war. During battle he had shot and killed his company commander, a new and inexperienced officer who was waving a white flag to surrender the unit to the Vietnminh. The veteran realized from experience that the unit still had a chance to survive while, if surrendered, they would probably be executed totally. The patient felt positively toward the officer, but had thought through the act of killing the officer and had no remorse for it.

In each of these three cases, the history of these events pointed up certain issues for that individual critical to understanding them as individuals, even though these events did not play a direct role in current PTSD or other disorders. These three cases described above, the refugee patients related these events matter-of-factly. This is not typical of clinically relevant traumatic events, which are usually told with much distress, often involving tears, hyperventilation, anguish, fear, and rage).

One reason to conduct interviews is for diagnostic purposes as in this case:

A 55 year old Vietnamese man presented with major depression, inability to learn English despite three years of instruction, frightening nightmares, and family problems. Formerly a government official, he had been imprisoned for four years. His early imprisonment had involved severe beatings

about the head with a thick bamboo piece, leading to lacerations and several episodes of unconsciousness. On three occasions his head had been held under water until he became unconscious. Later, during an extended period of malnutrition, he and other inmates had experienced severe diarrhea, a butterfly rash across the face, and confusion (suggestive of pellagra). On three other occasions of poor nourishment his ankles became edematous and he was too weak to work (suggestive of thiamine deficiency). Scores of other inmates died of similar beatings, head inundation, and malnutrition. He had loss of memory for prolonged periods in the prison. For example, although x-rays showed a mandibular fracture, he could only recall general beatings and pain about the head and could not remember a fractured jaw. In addition to several old lacerations about his head and back, there was an extensive EEG slow-wave deficit in the left tempero-parietal area suggesting a large a area of brain damage. His depressive and PTSD symptoms responded to tricyclic medication, but his inability to learn a new language persisted (consisted with left tempero-parietal damage). Consultation from several disciplines indicated that this latter disability was permanent. This information assisted us in obtaining social security disability and in guiding him towards an occupation which would not require learning English.

A second critical reason is to facilitate treatment, as in this case:

> A 21 year old single Cambodian college student, obtaining straight A's in school, presented with chronic headaches, sleep disturbance, and several minor symptoms of anxiety and depression. He worked four hours every night to help support his mother and four younger siblings. His father and second eldest brother had been killed in Cambodia, and he had been tortured as a 12 year old. His eldest brother, an ineffective and sometimes cowardly man, had recently left the family and gone to another state. The patient felt no emotions, had no friends, had never grieved his family losses, and could express no feelings about his previous victimization. Treatment consisted of weekly psychotherapy in which he was initially taught to experience and identify feelings here and now, progressing later to expression of feelings (grief) towards his father and second eldest brother and of feelings (rage) towards his eldest brother. Headaches ceased and he was able to establish close peer relationships with other students, including Cambodians.

Certainly the past cannot be changed, but it is evident from clinical work that many refugees cannot live gainfully in the present if the past continues to intrude and to undermine current adjustment. Nightmares and intrusive, uninvited and dysphoria- producing reveries from the past are indications

that past must receive attention if the future is to be optimal. For cases in which past traumatic events have already been adequately dealt with (as in the three cases reported above), the retelling of these stories is not disturbing to the individual (although they may be disturbing to the listener, hearing them for the first time).

PROCESS OF THE INTERVIEW

Victims of extreme psychosocial stressors and physical mistreatment generally do not spontaneously report these experiences, even in clinical settings. Somatic symptoms and relationship problems are frequent presenting complaints. This can occur for many reasons. The individual may not perceive a relationship between these past events and the current clinical problem. Memories of such experiences are often suppressed (even repressed) due to the emotional responses which they engender. Shame, guilt, remorse, grief and rage may be admixed in varying degrees. Despite an unwillingness to volunteer such information, victims often welcome the opportunity to reveal their secrets and explore their meaning in a supportive environment with a professional person experienced in helping refugees, as in the following case:

> A 43 year old Hmong widow had been bothered by fear of the dark for a decade. Her symptoms had become worse in the last year since the death of her husband, when she began to have panic attacks. In addition, she could not sleep without another person in the

room and the lights on. When other persons in the family objected to this, she began taking opium to sleep. She had been addicted to opium for ten months. Her original symptoms began following a mortar bombardment of her village in Laos. A mortar round hit nearby the patient and a younger woman, who were leading their several children out of the village. One of the patient's children took the main impact of the mortar. Although the child's abdominal and chest organs were visible, the child was conscious although obviously dying. The child had no hope of survival and could not be carried, yet to stay with the child would risk survival of the entire group. The mother waved the others on while she hurriedly dug a shallow grave for the child, pushing dirt over the child "to provide a proper burial". Successful treatment of her several diagnoses included an opioid withdrawal regimen, imipramine, desensitization, grief work, and a day program.

Routine inquiry about past violence should be a part of complete psychiatric evaluation of most refugee patients. (Clinical judgment is needed in the case of psychiatric, retarded, brain, damaged and certain other patients). Past stressors and mistreatment are often relevant (but not always) to refugees' current problems. This is especially apt to be true of individuals with depressive disorders, paranoid disorders, phobic and panic disorders, post-traumatic stress disorder, relationship problems, and failure of acculturation. Use of specific questions can aid in overcoming the patient's

suppression or repression of this material. Specific inquiry can also overcome the clinician's reluctance to address painful, even horrorific issues involving terrorism and inhuman behavior.

A key factor in such an interview is rapport. Victims and refugees are often distrustful of people in general. It is important that the patient understand the reason for this inquiry. It usually requires a few to several sessions to complete the trauma-related interview if victimization has occurred.

A practical approach is to first obtain the victim's story regarding the particular events, their sequence, the individual's behavior, thoughts and emotions at the time.Depending on the case, this may require one or several sessions. Subsequently, the patient's feelings (now and at the time) about these events can be explored. At times collateral sources of information are necessary, as in this case:

> A 62 year old Vietnamese woman presented with major depression and mood congruent psychotic depression. She expressed the wish to return to Vietnam "where I am a wealthy woman". Her family revealed that she had been imprisoned and tortured on two occasions, lasting two weeks each time. She bore scars on her shoulders, back and legs from the beatings. A nephew was shot to death in the head in front of her. She was herself then subjected to a mock execution.

> These issues were not raised by us immediately, but were eventually expressed by the patient later in her treatment when her treatment team (alerted to these past events) provided her with the opportunity to discuss them. This was done after she had recovered from her psychiatric symptoms.

In addition to the nature of the stressful events, the frequency, pattern or duration of the stressor or mistreatment should be sought. Effects on family relationships, friendships, occupation and other aspects of personal and social life should be explored.

This type of interview can result in emotional distress for the patient, especially if there are unresolved issues regarding these events, or they are related to the patient's current clinical disorder. Improperly handled, such interviews can exacerbate the isolation or alienation which the individual bears. If a translator is involved, this person may also be distressed if he or she (generally a refugee also) has experienced distress similar to the patient.

Unless undertaken in the context of a continuing therapeutic relationship, these topics are probably better avoided. Clinicians new to this type of interviewing may experience countertransference problems. Manifestations of countertransference problems include the following: failure to clarify elements of the patient's story and to facilitate a full account of the person's experience; premature or inadequate closure of the interview process; inability to empathize with the patient's human response to terrible events; lack of effort at aiding the patient to integrate these past experiences into their current and future life in some more adaptive fashion;

abandonment of the patient behind a seemingly rational excuse (e.g., "It's impossible to do psychotherapy across cultures" or "It's impossible to conduct psychotherapy through a translator" or "I don't understand this patient's culture" or "This patient's English isn't good enough to conduct counseling" or "These refugees are survivors -- they don't need help") or behind a political slogan (e.g., "Torture is a political problem, not a psychiatric problem" or "The [Communists or rightest dictator] created this problem; they can solve it" or "Helping the patient to sublimate their injuries undermines their rageful and righteous efforts at retribution and revenge"). In this regard, a recent World Health Organization (1986) panel has recommended, "The victims of organized violence should be legally entitled to equal access to health services."

The patient's emotional response to the interview should be noted, since this has both diagnostic and therapeutic implications. The individual may be cut off from his or her own feelings. For example, a Cambodian woman with mania described her husband's lengthy and horrible death via starvation as though she were describing a Sunday stroll. The expression of great affect may indicate that considerable bound-up feeling remains. For example, a depressed Vietnamese veteran of Dienbienphu (fighting on the French side) evidenced rapid speech, dilated pupils, tremulousness, agitation, tears, fear and anger in describing the events of that battle -- 34 years after the original events! Further history documented severe PTSD beginning with his current depression.

PREPARATION FOR WORKING WITH REFUGEES

Assessing and treating refugees require certain special knowledge and skills, but it does not require unique knowledge

or skills. For example, one need not have been a refugee to assess and treat refugees successfully. However, certain knowledge, skills, and experience are necessary to work effectively and comfortably in this clinical arena.

Informational background falls into four different categories. First, one should know the epidemiology of psychiatric disorder among migrants in general, and refugees in particular. Second, concepts about cross cultural assessment and treatment should be known. Third, the clinician should have some knowledge about cultural differences in general. Familiarity with some elements of the particular patient's culture is desirable whenever possible. Lastly, historical information about the particular refugee flight out of a locale, country or region can be valuable in ascertaining the context of the patient's particular history and current situation.

Skills required to treat refugees overlap with skills in treating many other categories of patients. In addition to experience with the common diagnostic entities, the clinician should be familiar with the care of victims of violence or tumult (e.g., rape, assault, car or plane crash, tornado, flood, race riots, hostage), the treatment of post-traumatic stress disorder, and the assessment and care of patients with organic brain syndromes. Clinicians should also be able to work with patients who have migrated, patients from other ethnic or cultural backgrounds, patients who speak limited or no English, and patients who are illiterate.

Experience is a critical factor in any area of professional practice, but especially so in caring for refugees. Trainees and those new to the field should obtain supervision from one who has experience with this group. For seasoned clinicians new to

work with refugees, a period of supervision by a clinician experienced in treating refugees may suffice.

Caring for refugees involves certain burdens. Extra time is required to collect the necessary data, often via a translator. More extensive data are required than for the usual case. Neurological, psychological, genetic, familial, social and cultural factors interact to produce complex cases requiring an array of phased interventions, involving multiple professionals and agencies. Funding for adequate care may be difficult to obtain. Still, the rewards in caring for this group can overcome the burdens and dilemmas. This work provides an opportunity to counter some of people's inhumanity to their fellows, to oppose evil and violence with help and care. Gratification results from the improvement and recovery of seriously disordered persons. Professional experience gained from this group generalizes to virtually all other clinical populations. The limits of one's education, training and skill are tested as virtually any and all clinical entities are encountered.